Connecticut Department of Public Health
Immunization Program
Varicella Case Report Form

(revised March 24, 2016)

Person reporting: _____ Phone: (_____)_____-_____

Reporting site/clinic: _____ City: _____

Date reported: _____/_____/_____ Reporting site type: ☐ School ☐ Day care ☐ Physician ☐ Health department

Patient's healthcare provider (if not the person reporting): _____ Phone: (_____)_____-_____

Demographic information

Patient name: _____ DOB: _____/_____/_____ Age:_____

Street address: _____ City: _____ Zip: _____

Parent/Guardian name (optional): _____ Phone: (_____)_____-_____

Sex: ☐ Male ☐ Female ☐ Other Country of birth: ☐ USA ☐ Other _____ ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ Black ☐ Asian ☐ Hawaiian/Pacific Islander
☐ American Indian/Alaska Native ☐ Unknown ☐ Other (specify) _____

Attends: ☐ School ☐ Day care ☐ Work ☐ College ☐ Other _____
Name of institution: _____ City: _____

Clinical data

Rash onset: _____/_____/_____ Fever? ☐ Yes, temperature _____°F Fever onset: _____/_____/_____
☐ No ☐ Unknown

Number of lesions: ☐ <50 ☐ 50-249 ☐ 250-499 ☐ >500

Rash description: ☐ Generalized ☐ Local ☐ Unknown

Did the rash crust? ☐ Yes, rash lasted _____ days before all crusted ☐ No, rash lasted _____ days ☐ Unknown

Diagnosed by: ☐ Physician/nurse ☐ Parent/guardian ☐ School ☐ Self ☐ Other_____

Laboratory tests

	Date	Positive	Negative	Not done
DFA		☐	☐	☐
PCR		☐	☐	☐
Culture		☐	☐	☐
IgM		☐	☐	☐
IgG		☐	☐	☐
Other (specify) _____		☐	☐	☐

Medical history

Is the patient pregnant?
☐ Yes, due date: _____/_____/_____ ☐ No ☐ Unknown

Has the patient been diagnosed with varicella in the past?
☐ Yes ☐ No ☐ Unknown

Varicella vaccine dates:
#1 _____/_____/_____ #2 _____/_____/_____

For patients born after the year 2000, is the patient up to date with varicella-containing vaccine (at least one dose by 16 months, at least 2 doses by 7 years)?

☐ Yes ☐ Unknown

☐ No, reason: ☐ MD diagnosis of previous disease at age _____ or date (if known) _____/_____/_____
☐ Lab evidence of previous disease ☐ Born outside the U.S. ☐ Medical contraindication
☐ Never offered vaccine ☐ Parent/patient refusal ☐ Parent/patient forgot to vaccinate
☐ Religious exemption ☐ Too young to vaccinate ☐ Parent/patient report of previous disease
☐ Other _____ ☐ Unknown

Did the patient develop any complications that were diagnosed by a healthcare provider? [Check all that apply]	Yes	No	Unknown
Skin/soft tissue infection	☐	☐	☐
Cerebellitis/ataxia	☐	☐	☐
Encephalitis	☐	☐	☐
Dehydration/hypovolemia	☐	☐	☐
Hemorrhagic condition	☐	☐	☐
Pneumonia (diagnosed by ☐ X-ray ☐ MD ☐ unknown)	☐	☐	☐
Meningitis	☐	☐	☐
Other complications (Specify: _____)	☐	☐	☐

Was the patient treated with antivirals? ☐ Yes, name: _____ Started on _____/_____/_____
☐ No or N/A ☐ Unknown

Is the patient immunocompromised due to a medical condition or treatment?
☐ Yes, specify _____
☐ No ☐ Unknown

Does the patient have any co-morbid medical conditions?
☐ Yes, specify _____ _____
☐ No ☐ Unknown

Did the patient die from varicella or complications (including secondary infection) associated with varicella?
☐ No ☐ Unknown
☐ Yes, date of death: _____/_____/_____
Autopsy performed? ☐ Yes ☐ No ☐ Unknown
Cause of death: _____

Was the patient hospitalized? ☐ No ☐ Unknown
☐ Yes, name of hospital _____
Admit date: _____/_____/_____ Discharge date: _____/_____/_____
Primary reason for hospitalization:
☐ Severe varicella presentation ☐ Unknown
☐ Varicella-related complication ☐ Observation
☐ Administration of IV treatment ☐ Isolation
☐ Non-varicella hospitalization with coincident varicella
☐ Other _____

Return form to: Connecticut Department of Public Health
Immunization Program
410 Capitol Ave, MS #11MUN
Hartford, CT 06134
or fax form to (860) 509-7945

Questions? Call (860) 509-7929

DPH use only CTEDSS ID: _____

Case status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case

Epi-linked to another case? ☐ Yes, case ID _____ ☐ No ☐ Unknown

Outbreak linked? ☐ Yes, name of outbreak: _____ ☐ No ☐ Unknown